		FOR OHF USE					

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2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0027565

Facility Name: Manorcare at Urbana

Address: '600 N. Coler Ave. (Number) Urbana (City) 61801 (Zip Code)

County: Champaign

Telephone Number: '(217) 367 - 1191 **Fax #** '(217) 344 - 4082

IDPA ID Number: 520886946007

Date of Initial License for Current Owners: '11/01/81

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		X	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Craig Dekany, Reimb. Manager **Telephone Number:** (419) 252 - 5740

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 6/01/99 to 5/31/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment

Officer or Administrator of Provider	(Signed) _____ (Date)
	(Type or Print Name) Barry Lazarus
	(Title) VP of Reimbursement
Paid Preparer	(Signed) _____ (Date)
	(Print Name and Title)
	(Firm Name & Address)
	(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

DPA 3745 (N-4-99) IL478-2471

Print Previe

x

STATE OF ILLINOIS

Facility Name & ID Number Manorcare at Urbana # 0027565 Report Period Beginning: 6/01/99 Ending: 5/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	100	Skilled (SNF)	100	36,600	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	100	TOTALS	100	36,600	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	1,092	908	4,707	6,707	8
9	SNF/PED					9
10	ICF	18,559	7,972	70	26,601	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	19,651	8,880	4,777	33,308	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.01%

D. How many bed-hold days during this year were paid by Public Aid?
31 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 11 / 01 / 81

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 11 / 01 / 81 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 23 and days of care provided 3991

Medicare Intermediary Blue Cross of Maryland

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [ ] NO [X]

Tax Year: 12 / 31 / 00 Fiscal Year: 05 / 31 / 00

* All facilities other than governmental must report on the accrual basis.

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IF AN ERROR OCCURS IN LINE 8, 16 OR 28, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

STATE OF ILLINOIS

Facility Name & ID Number Manorcare at Urbana # 0027565 Report Period Beginning: 6/01/99 Ending: 5/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	160,108	13,235	21,574	194,917	653	195,570	0	195,570			1
2	Food Purchase		143,326		143,326		143,326	(86)	143,240			2
3	Housekeeping	81,422	10,338	843	92,603		92,603	0	92,603			3
4	Laundry	31,673	12,819	3,469	47,961		47,961	(8,620)	39,341			4
5	Heat and Other Utilities			79,225	79,225	7,755	86,980	0	86,980			5
6	Maintenance	28,220	7,780	48,635	84,635		84,635	0	84,635			6
7	Other (specify):*			(242)	(242)		(242)	0	(242)			7
8	TOTAL General Services	301,423	187,498	153,504	642,425	8,408	650,833	(8,706)	642,127			8
	B. Health Care and Programs											
9	Medical Director			8,995	8,995		8,995	0	8,995			9
10	Nursing and Medical Records	1,157,703	116,516	28,473	1,302,692	10,898	1,313,590	0	1,313,590			10
10a	Therapy	224,097	6,140	30,911	261,148		261,148	0	261,148			10a
11	Activities	31,664	2,638	3,270	37,572		37,572	0	37,572			11
12	Social Services	36,402	55	1,534	37,991	437	38,428	0	38,428			12
13	Nurse Aide Training							0				13
14	Program Transportation							0				14
15	Other (specify):*							0				15
16	TOTAL Health Care and Programs	1,449,866	125,349	73,183	1,648,398	11,335	1,659,733		1,659,733			16
	C. General Administration											
17	Administrative	81,043		195,965	277,008	(60,776)	216,232	0	216,232			17
18	Directors Fees							0				18
19	Professional Services			2,049	2,049	(836)	1,213	(1,213)				19
20	Dues, Fees, Subscriptions & Promotions			33,746	33,746	(2,708)	31,038	(15,898)	15,140			20
21	Clerical & General Office Expenses	107,385	26,728	264,038	398,151		398,151	(234,954)	163,197			21
22	Employee Benefits & Payroll Taxes			337,631	337,631	874	338,505	0	338,505			22
23	Inservice Training & Education			3,432	3,432		3,432	0	3,432			23
24	Travel and Seminar			12,832	12,832	2,708	15,540	0	15,540			24
25	Other Admin. Staff Transportation							0				25
26	Insurance-Prop.Liab.Malpractice			51,017	51,017		51,017	0	51,017			26
27	Other (specify):*							0				27
28	TOTAL General Administration	188,428	26,728	900,710	1,115,866	(60,738)	1,055,128	(252,065)	803,063			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,939,717	339,575	1,127,397	3,406,689	(40,995)	3,365,694	(260,771)	3,104,923			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

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IF AN ERROR OCCURS IN LINE 37 OR 44, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

Facility Name & ID Number Manorcare at Urbana # 0027565 Report Period Beginning: 6/01/99 Ending: 5/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	D. Ownership											
30	Depreciation			193,321	193,321	13,390	206,711	(48,870)	157,841			30
31	Amortization of Pre-Op. & Org.							0				31
32	Interest			392	392	27,605	27,997	(11,601)	16,396			32
33	Real Estate Taxes			45,199	45,199		45,199	0	45,199			33
34	Rent-Facility & Grounds			45,000	45,000		45,000	(1,200)	43,800			34
35	Rent-Equipment & Vehicles			27,426	27,426		27,426	0	27,426			35
36	Other (specify):*							0				36
37	**TOTAL Ownership**			311,338	311,338	40,995	352,333	(61,671)	290,662			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation							0				38
39	Ancillary Service Centers		87,925		87,925		87,925	0	87,925			39
40	Barber and Beauty Shops		9,365		9,365		9,365	0	9,365			40
41	Coffee and Gift Shops							0				41
42	Provider Participation Fee			54,900	54,900		54,900	0	54,900			42
43	Other (specify):*		6,629		6,629		6,629	0	6,629			43
44	**TOTAL Special Cost Centers**		103,919	54,900	158,819		158,819		158,819			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,939,717	443,494	1,493,635	3,876,846	0	3,876,846	(322,442)	3,554,404			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

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FOR LINES 1 THRU 28, ENTER ONLY ONE LINE REFERENCE PER ROW. IF SIMILAR ADJUSTMENTS ARE MADE TO MORE THAN ONE LINE, ENTER THE ADDITIONAL ADJUSTMENTS ON LINE 29 OF THIS SCHEDULE AND DETAIL THEM ON PAGE 5A.

Facility Name & ID Number Manorcare at Urbana # 0027565 **Report Period Beginning:** 6/01/99 **Ending:** 5/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7 In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(86)	2		4
5	Telephone, TV & Radio in Resident Rooms	(216)	21		5
6	Rented Facility Space	(1,200)	34		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients	(8,620)	4		8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(11,601)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(4,768)	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions	(48,870)	30		15
16	Personal Expenses (Including Transportation)	(1,037)	21		16
17	Non-Care Related Fees				17
18	Fines and Penalties	(8,683)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(1,213)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(220,250)	21		24
25	Fund Raising, Advertising and Promotional	(15,898)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (322,442)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (322,442)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

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Detail lines 29 and 35 of Page 5 starting in B44. **DO NOT DRAG AND DROP CELLS.**

The amounts in column F will transfer to the Adj. Summary column automatically.
The amounts in the Adj. Summary column are linked to pages Summary A and B.

To Print the Other Adjustments you have entered.

1. **Highlight the other adjustments you have entered starting at B44 and continue to your last entry. Be sure the columns highlighted are B thru G.**
2. **Push the Print Other Adjustments button.**

STATE OF ILLINOIS **Page 5A**

Facility Name Manorcare at Urbana
ID# 0027565
Report Period Beginning: 6/01/99
Ending: 5/31/00

Print Other Adjustment

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	Sch V	Adj. Summary
	The information listed in B13 thru G43 is from Page 5.				
1	Day Care	0	0	Line 1	0
2	Other Care for Outpatients	0	0	Line 2	(86)
3	Governmental Sponsored Special Programs	0	0	Line 3	0
4	Non-Patient Meals	(86)	2	Line 4	(8,620)
5	Telephone, TV & Radio in Resident Rooms	(216)	21	Line 5	0
6	Rented Facility Space	(1,200)	34	Line 6	0
7	Sale of Supplies to Non-Patients	0	0	Line 7	0
8	Laundry for Non-Patients	(8,620)	4	Line 8	(8,706)
9	Non-Straightline Depreciation	0	0	Line 9	0
10	Interest and Other Investment Income	(11,601)	32	Line 10	0
11	Discounts, Allowances, Rebates & Refunds	0	0	Line 10a	0
12	Non-Working Officer's or Owner's Salary	0	0	Line 11	0
13	Sales Tax	(4,768)	21	Line 12	0
14	Non-Care Related Interest	0	0	Line 13	0
15	Non-Care Related Owner's Transactions	(48,870)	30	Line 14	0
16	Personal Expenses (Including Transportation)	(1,037)	21	Line 15	0
17	Non-Care Related Fees	0	0	Line 16	0
18	Fines and Penalties	(8,683)	21	Line 17	0
19	Entertainment	0	0	Line 18	0
20	Contributions	0	0	Line 19	(1,213)
21	Owner or Key-Man Insurance	0	0	Line 20	(15,898)
22	Special Legal Fees & Legal Retainers	(1,213)	19	Line 21	(234,954)
23	Malpractice Insurance for Individuals	0	0	Line 22	0
24	Bad Debt	(220,250)	21	Line 23	0
25	Fund Raising, Advertising and Promotional	(15,898)	20	Line 24	0
26	Income & IL Personal Property ReplacementTaxes	0	0	Line 25	0
27	Nurse Aide Training for Non-Employees	0	0	Line 26	0
28	Yellow Page Advertising	0	0	Line 27	0
29	Non-Paid Workers	0	0	Line 28	(252,065)
30	Donated Goods	0	0	Line 29	(260,771)
31	Amortization Expense	0	0	Line 30	(48,870)
32				Line 31	0
33				Line 32	(11,601)
34				Line 33	0
35				Line 34	(1,200)
36				Line 35	0
37				Line 36	0
38				Line 37	(61,671)
39				Line 38	0
40				Line 39	0
41				Line 40	0
42				Line 41	0
43				Line 42	0
44				Line 43	0
45				Line 44	0
46				Line 45	(322,442)

Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference
1	2	3	4	5	6	7	9	10	10a	11	12	13

Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference
14	15	17	18	19	20	21	22	23	24	25	26	27

Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference	Reference
30	31	32	33	34	35	36	38	39	40	41	42	43

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS — Summary A

Facility Name & ID Number Manorcare at Urbana # 0027565 Report Period Beginning: 6/01/99 Ending: 5/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(86)	0	0	0	0	0	0	0	0	0	0	(86)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(8,620)	0	0	0	0	0	0	0	0	0	0	(8,620)	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(8,706)	0	0	0	0	0	0	0	0	0	0	(8,706)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(1,213)	0	0	0	0	0	0	0	0	0	0	(1,213)	19
20	Fees, Subscriptions & Promotions	(15,898)	0	0	0	0	0	0	0	0	0	0	(15,898)	20
21	Clerical & General Office Expenses	(234,954)	0	0	0	0	0	0	0	0	0	0	(234,954)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(252,065)	0	0	0	0	0	0	0	0	0	0	(252,065)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(260,771)	0	0	0	0	0	0	0	0	0	0	(260,771)	29

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 3.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS — Summary B

Facility Name & ID Number Manorcare at Urbana # 0027565 Report Period Beginning: 6/01/99 Ending: 5/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(48,870)	0	0	0	0	0	0	0	0	0	0	(48,870)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(11,601)	0	0	0	0	0	0	0	0	0	0	(11,601)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	(1,200)	0	0	0	0	0	0	0	0	0	0	(1,200)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(61,671)	0	0	0	0	0	0	0	0	0	0	(61,671)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(322,442)	0	0	0	0	0	0	0	0	0	0	(322,442)	45

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 4.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT
FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Facility Name & ID Number: Monterrey at Urbana # 0927565 Report Period Beginning: 6/01/99 Ending: 5/31/00

VII. RELATED PARTIES

Show Pgs 6A thru 6 | Show Pgs 6E thru 6 | Hide Pgs 6A thru 6

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
HCR ManorCare, Inc.	100	Health Care & Retirement Corporation of America (SEE R.O. COST REPORT)	Toledo, OH			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger Item		4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		
1	V	5ee	Home Office Allocation	$ 195,965	HCR ManorCare, Inc.	100.00%	$ 195,965	$		1
2	V	Page								2
3	V	2								3
4	V									4
5	V	10a	Therapy Management	18,154	Heartland Management Service	100.00%	18,154			5
6	V									6
7	V									7
8	V									8
9	V									9
10	V									10
11	V									11
12	V									12
13	V									13
14	Total			$ 214,119		$	214,119	$ -		14

Sum_6

* Total must agree with the amount recorded on line 34 of Schedule VI.

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DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

Line 1	Line 2	Line 3	Line 4	Line 5	Line 6	Line 7	Line 9	Line 10	Line 10a	Line 11	Line 12	Line 13	Line 14	Line 15	Line 17	Line 18	Line 19	Line 20	Line 21	Line 22	Line 23	Line 24	Line 25	Line 26	Line 27	Line 30	Line 31	Line 32	Line 33	Line 34	Line 35	Line 36	Line 38	Line 39	Line 40	Line 41	Line 42	Line 43

x

Facility Name & ID Number Manorcare at Urbana # 0027565 Report Period Beginning: 6/01/99 Ending: 5/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

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STATE OF ILLINOIS

Facility Name & ID Number Manorcare at Urbana # 0027565 Report Period Beginning: 6/01/99 Ending: 5/31/00

VIII. ALLOCATION OF INDIRECT COSTS

Show Pgs 8A thru 8 | Show Pgs 8E thru 8 | Hide Pgs 8A thru 8

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: HCR ManorCare, Inc.
Street Address: 333 North Summti St.
City / State / Zip Code: Toledo, OH 43604
Phone Number: (419) 252 - 5500
Fax Number: ('419) 254 - 5494

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Accumulated Cost	100,182,693	357 Nurs. Fac.	$ 388,478	$ 221,496	168,360	$ 653	1
2	5	Utilities	Accumulated Cost	100,182,693	357 Nurs. Fac.	4,614,666		168,360	7,755	2
3	10	Nursing	Accumulated Cost	100,182,693	357 Nurs. Fac.	6,247,503	4,177,723	168,360	10,499	3
4	17	General & Administrative	Accumulated Cost	100,182,693	357 Nurs. Fac.	80,443,795	26,746,978	168,360	135,188	4
5	22	Employee Benefits	Accumulated Cost	100,182,693	357 Nurs. Fac.	520,233		168,360	874	5
6	30	Depreciation	Accumulated Cost	100,182,693	357 Nurs. Fac.	7,968,019		168,360	13,390	6
7	32	Interest	Direct Allocation	1		27,605		1	27,605	7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 100,210,299	$ 31,146,197		$ 195,964	25

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Facility Name & ID Number Manorcare at Urbana # 0027565 Report Period Beginning: 6/01/99 Ending: 5/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Conv. Sub. Debentures		X	Facility			$ 871,900	$ 871,900			$ 27,605	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7								Interest Expense Other			392	7
8								Interest Income Offset			(11,601)	8
9	TOTAL Facility Related						$ 871,900	$ 871,900			$ 16,396	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 871,900	$ 871,900			$ 16,396	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

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Facility Name & ID Number Manorcare at Urbana # 0027565 Report Period Beginning: 6/01/99 Ending: 5/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	45,199	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	45,199	2
3. Under or (over) accrual (line 2 minus line 1).	$		3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	45,199	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ _____ For 19 ____ Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	45,199	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995	41,824	8
	1996	43,028	9
	1997	43,959	10
	1998	45,176	11
	1999	45,199	12

R/E TAX PAYMENTS

1999 22,600

2000 22,599

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**

This denial must be no more than four years old at the time the cost report is filed.

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Facility Name & ID Number Manorcare at Urbana # 0027565 Report Period Beginning: 6/01/99 Ending: 5/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 23,663 B. General Construction Type: Exterior Masonry Frame Steel Number of Stories 3

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		1981	$ 68,476	1
2					2
3	TOTALS			$ 68,476	3

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IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Show Pgs 12A & 12 | Show Pgs 12C and 12 | Hide Pgs 12A thru 12

STATE OF ILLINOIS

Facility Name & ID Number Manorcare at Urbana # 0027565 Report Period Beginning: 6/01/99 Ending: 5/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	100			1966	$ 1,022,540	$ 16,391		$ 16,391	$	$ 994,942	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9	Current Year Depreciation					78,407		78,407		450,211	9
10				1984	9,538						10
11				1985	15,438						11
12				1986	31,912						12
13				1987	83,892						13
14				1988	11,031						14
15				1989	76,691						15
16				1990	36,584						16
17				1991	19,488						17
18				1992	197,124						18
19				1993	70,653						19
20				1994	82,201						20
21				1995	140,479						21
22	CAPITALIZED LABOR			1996	7,272						22
23	RENOVATE SHOWER ROOM			1996	18,516						23
24	UPGRADE ACTIVITY ROOM			1996	2,036						24
25	UPGRADE BOOKKEEPING OFFICE			1996	1,594						25
26	WALLVINYL/HANDRAILS 2ND FLOOR			1996	6,291						26
27	UPGRADE 10 RESIDIENT ROOMS			1996	4,441						27
28	HANDRAILS - 3RD FLOOR			1996	1,000						28
29	INSTALL CARPET			1996	2,098						29
30	WATER HEATER			1996	886						30
31	PLUMBING			1996	1,103						31
32	REFRIGERATOR COMPRESSOR			1996	1,067						32
33	WALLCOVERINGS/CORNER GUARDS			1996	1,236						33
34	PAINTING			1996	1,565						34
35	CARPET			1996	2,414						35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$ 94,798		$ 94,798	$	$ 1,445,153	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

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IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12

STATE OF ILLINOIS

Facility Name & ID Number Manorcare at Urbana # 0027565 Report Period Beginning: 6/01/99 Ending: 5/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9	ELECTRICAL/LIGHTING			1996	1,753						9
10	INSTALL FLOOR TILES			1996	5,884						10
11	RENOVATION/DECORATING			1996	1,879						11
12	INSTALL PARKING GATE			1996	3,384						12
13	HANDRAILS			1997	4,611						13
14	WALLVINYL/PAINT			1997	3,050						14
15	CEILING/WALL REPAIRS			1997	2,860						15
16	FURNISH & INSTALL TILES			1997	7,192						16
17	HOT WATER HEATER/PLUMBING			1997	5,351						17
18	ELECTRICAL			1997	2,233						18
19	RETIREMENTS			1984	(95)						19
20	RETIREMENTS			1987	(45,556)						20
21	RETIREMENTS			1992	(14,562)						21
22	WALLVINYL/PAINTING			1997	4,066						22
23	SEWER REPAIRS			1997	5,667						23
24	HVAC/EXHAUST			1997	4,902						24
25	CHILLER REPLACEMENT			1997	24,300						25
26	FACILITY PLAN ALLOC.			1997	2,759						26
27	TV INSPECTION RPT			1997	710						27
28	INSTALL EMERGENCY GENERATOR			1998	63,013						28
29	PLUMBING			1998	4,863						29
30	FLOOR TILE			1998	10,883						30
31	DRYWALL			1998	1,750						31
32	CEILING			1998	1,750						32
33	INSTALL NEW LOCKS			1998	1,202						33
34	CORPORATE OVERHEAD			1998	1,702						34
35	CONSTRUCT LARGER ENTRYWAY			1998	1,964						35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Previe

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12

STATE OF ILLINOIS

Facility Name & ID Number Manorcare at Urbana # 0027565 Report Period Beginning: 6/01/99 Ending: 5/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9	IV INSPECTION RPT										9
10	ELEVATOR EQUIP EVAL.			1998	700						10
11	ROOF INSPECTION SURVEY			1998	500						11
12	MILLWORK			1998	12,203						12
13	CARPENTRY			1998	12,751						13
14	FINISH/STUD			1998	14,211						14
15	FLOORING			1998	13,543						15
16	PAINTING/WALLCOVER			1998	31,598						16
17	GENERAL CONTRACTORS			1998	14,108						17
18	CARPETING			1998	2,879						18
19	MASONRY			1998	1,400						19
20	SIGNAGE			1998	12,197						20
21	ROOFING			1998	9,618						21
22	PLUMBING			1998	5,200						22
23	ELECTRICAL			1998	8,599						23
24	HVAC/EXHAUST (CORRECTS LINE 32, PAGE 12A)			1998	(3,600)						24
25	ELECTRICAL			1999	1,520						25
26	CONSTRUCTION, URBANA FACILITY			1999	4,044						26
27	ADVANTAGE 1000 SYSTEM, OUTLETS			1999	14,142						27
28	ELECTRONICS / COMMUNICATION			1999	2,616						28
29	STAINLESS STEEL WALLS FOR KITCHEN			1999	2,437						29
30	NEW PHONE LINES FOR RESIDENT ROOMS			2000	3,822						30
31	DOOR UPGRADES			2000	3,915						31
32	MAGNETIC DOOR HOLDERS			2000	4,046						32
33	RETIREMENTS			2000	(109,900)						33
34	MEDICAID ADJUSTMENT - LAND/BLDG			1995	1,241						34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

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STATE OF ILLINOIS

Facility Name & ID Number Manorcare at Urbana # 0027565 Report Period Beginning: 6/01/99 Ending: 5/31/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 403,251	$ 49,653	$ 49,653	$		$ 233,369	37
38	Current Year Purchases	65,523						38
39	Fully Depreciated Assets	(47,468)						39
40	Home Office			13,390	13,390			40
41	TOTALS	$ 421,306	$ 49,653	$ 63,043	$ 13,390		$ 233,369	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	N/A			$	$	$	$		$	42
43										43
44										44
45										45
46	TOTALS			$	$	$	$		$	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ #VALUE!	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 144,451	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 157,841	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ 13,390	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 1,678,522	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52	STEP-UP BUILDING	$ 1,270,612	$ 48,870	$ 908,162	52
53					53
54					54
55					55
56					56
57	TOTALS	$ 1,270,612	$ 48,870	$ 908,162	57

G. Construction-in-Progress

	Description	Cost	
58	CIP	$ 41,323	58
59			59
60			60
61		$ 41,323	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Print Previe

x

Facility Name & ID Number Manorcare at Urbana # 0027565 Report Period Beginning: 6/01/99 Ending: 5/31/00

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Coler Park Carle Clinic

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [X] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	Parking Lot				45,000			5
6	Rental Income Offset				(1,200)			6
7	TOTAL				$ 43,800 **			7

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [X] YES [ ] NO

16. Rental Amount for movable equipment: $ 27,426 Description: O2 Concentrators, Wheelchairs, Gerichairs, Elect. Beds, Etc.
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	N/A		$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

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Facility Name & ID Number Manorcare at Urbana # 0027565 Report Period Beginning: 6/01/99 Ending: 5/31/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   [ ] YES
   [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

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x

Facility Name & ID Number Manorcare at Urbana # 0027565 Report Period Beginning: 6/01/99 Ending: 5/31/00

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service		Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a	2,990	hrs	$ 70,266		$ 7,495	$ 2,836	2,990	$ 80,597	1
2	Licensed Speech and Language Development Therapist	10a	1,574	hrs	51,898		1,213		1,574	53,111	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	10a	5,059	hrs	101,933		22,203	3,304	5,059	127,440	4
5	Physician Care			visits							5
6	Dental Care			visits							6
7	Work Related Program			hrs							7
8	Habilitation			hrs							8
9	Pharmacy	39		# of prescrpts				87,925		87,925	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Exceptional Care Program										12
13	Other (specify):										13
14	TOTAL				$ 224,097		$ 30,911	$ 94,065	9,623	$ 349,073	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

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Facility Name & ID Number Manorcare at Urbana # 0027565 Report Period Beginning: 6/01/99 Ending: 5/31/00

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 5/31/00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 161,466	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 179,451)	398,424		3
4	Supply Inventory (priced at)	15,518		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	7,113		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 582,521	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	63,330		13
14	Buildings, at Historical Cost	3,295,220		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	417,399		16
17	Accumulated Depreciation (book methods)	(2,593,498)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): CIP	41,323		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,223,774	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,806,295	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 39,102	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	94,332		30
31	Accrued Taxes Payable (excluding real estate taxes)	16,346		31
32	Accrued Real Estate Taxes(Sch.IX-B)	45,199		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Liabilities	30,050		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 225,029	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 225,029	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,581,266	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,806,295	$	48

***(See instructions.)**

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Facility Name & ID Number Manorcare at Urbana # 0027565 Report Period Beginning: 6/01/99 Ending: 5/31/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 4,334,089	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 4,334,089	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(326,737)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (326,737)	17
	B. Transfers (Itemize):		
18	**Change in Interdivision**	(2,426,086)	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ (2,426,086)	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,581,266	24 *

*** This must agree with page 17, line 47.**

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Facility Name & ID Number Manorcare at Urbana # 0027565 Report Period Beginning: 6/01/99 Ending: 5/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,927,112	1
2	Discounts and Allowances for all Levels	(1,088,915)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,838,197	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	595,349	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 595,349	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	1,037	12
13	Barber and Beauty Care	10,554	13
14	Non-Patient Meals	86	14
15	Telephone, Television and Radio	216	15
16	Rental of Facility Space	1,200	16
17	Sale of Drugs	72,883	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	10,016	19
20	Radiology and X-Ray		20
21	Other Medical Services	350	21
22	Laundry	8,620	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 104,962	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	11,601	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 11,601	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,550,109	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	$ 642,425	31
32	Health Care	1,648,398	32
33	General Administration	1,115,866	33
	B. Capital Expense		
34	Ownership	311,338	34
	C. Ancillary Expense		
35	Special Cost Centers	158,819	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,876,846	40
41	**Income before Income Taxes (line 30 minus line 40)****	(326,737)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (326,737)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

******Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

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Facility Name & ID Number Manorcare at Urbana # 0027565 Report Period Beginning: 6/01/99 Ending: 5/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	4,862	5,047	$ 119,356	$ 23.65	1
2	Assistant Director of Nursing					2
3	Registered Nurses	10,426	11,797	180,352	15.29	3
4	Licensed Practical Nurses	13,281	16,256	219,047	13.47	4
5	Nurse Aides & Orderlies	59,971	67,791	618,644	9.13	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	5,439	6,397	197,430	30.86	7
8	Rehab/Therapy Aides	2,383	2,581	26,667	10.33	8
9	Activity Director					9
10	Activity Assistants	3,946	4,214	31,664	7.51	10
11	Social Service Workers	1,702	1,984	36,402	18.35	11
12	Dietician	17,736	20,035	160,108	7.99	12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	1,980	2,252	28,220	12.53	17
18	Housekeepers	10,768	12,070	81,422	6.75	18
19	Laundry	3,560	4,178	31,673	7.58	19
20	Administrator	2,112	2,224	81,043	36.44	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,810	8,295	107,385	12.95	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,060	2,332	20,304	8.71	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	147,036	167,453	$ 1,939,717 *	$ 11.58	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	Monthly	8,995	9,3	36
37	Medical Records Consultant	Monthly	250	10,5	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	149	10,5	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	Monthly	437	12,5	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 9,831		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	212	$ 6,788	10,3	50
51	Licensed Practical Nurses	268	6,440	10,3	51
52	Nurse Aides	308	5,385	10,3	52
53	TOTAL (lines 50 - 52)	788	$ 18,613		53

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STATE OF ILLINOIS

Facility Name & ID Number Manorcare at Urbana # 0027565 Report Period Beginning: 6/01/99 Ending: 5/31/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Dave Giesinger	Administrator	0.00%	$ 12,967
Dorothy Mikucki	Administrator	0.00%	34,848
Jan Tholman	Administrator	0.00%	3,242
Deb Porter	Administrator	0.00%	29,986
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 81,043

B. Administrative - Other

Description	Amount
Management Fees	$ 195,965
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 195,965

C. Professional Services

Vendor/Payee	Type	Amount
	Legal	$ 1,213
	Pharmacy	149
	Social Service	437
	Medical Records	250
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 2,049

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 23,146
Unemployment Compensation Insurance	
FICA Taxes	172,155
Employee Health Insurance	122,875
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Retirement Plan Expense	9,685
Employee Appreciation	2,877
Other Employee Benefits	3,529
Employee Vaccinations	864
Employee Uniforms	2,499
Home Office Allocation	874
TOTAL (agree to Schedule V, line 22, col.8)	$ 338,505

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 674
Advertising: Employee Recruitment	8,246
Health Care Worker Background Check	1,500
(Indicate # of checks performed 1250)	
Dues & Subscriptions	4,720
Advertising	5,670
Public Relations	2,271
Yellow Page Advertising	7,957
Less: Public Relations Expense	(2,271)
Non-allowable advertising	(5,670)
Yellow page advertising	(7,957)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 15,140

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 14,465
In-State Travel	217
Seminar Expense	858
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 15,540

* Attach copy of IMRF notifications

**See instructions.

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Facility Name & ID Number Manorcare at Urbana # 0027565 Report Period Beginning: 6/01/99 Ending: 5/31/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
					Amount of Expense Amortized Per Year								
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

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Facility Name & ID Number Manorcare at Urbana # 0027565 Report Period Beginning: 6/01/99 Ending: 5/31/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IHCA 967**

(3) Did the nursing home make political contributions or payments to a politica
action organization? **NO** If YES, have these costs
been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the
end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period?

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **36,780** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures
consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for
Schedule VII)? YES NO **X** If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department
of Public Aid during this cost report period. $ **54,900**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V
for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to
the Department of Public Aid, in addition to the daily rate, been properly classified
in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for
the patient census listed on page 2, Section B? **NO** For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach
a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits
on Schedule V. $ **N/A** Has any meal income been offset against
related costs? **YES** Indicate the amount. $ **86**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **YES**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for
residents? **NO** If YES, please indicate the amount of income earned from such a
program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other
times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted
out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such
transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the
cost report require that a copy of this audit be included with the cost report. Has this copy
been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted ou
out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services
performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.